journal of SOCIAL HYGIENE

Vol. 38 June 1952 No. 6

IN THIS ISSUE

JUNE 1952

About our cover . . .

An English family on the beach at Skegness on Britain's east coast. Fifteenth of a series of Journal covers on family life . . . photograph courtesy of British Information Services.

Harriett Scantland, Editor
Elizabeth McQuaid, Assistant Editor

Eleanor Shenehon, Editorial Consultant

THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: $3.00 per year. Single copy: 35¢.

The ramparts we watch

by Governor Henry F. Schricker

A speech for Social Hygiene Day in Indianapolis April 29, 1952

For the third time in 34 years—only the span of a young man's life—our country is conscripting young men into the Armed Forces of the nation. In World War I, and in the terrible war only a few years past, our forces vanquished the enemy, and we pray that the present conflict too may be successfully resolved.

Now, as then, our defense lies with the young men of our nation. What are we giving them besides a uniform and our hopes and prayers? The strongest armor we can give them is strong bodies, minds and spirits—and the belief that their nation, their communities and their homes are worth fighting for, worth coming home to. We spend billions on the modern mechanization of our fighting forces, billions on atomic weapons and the other materials for making war today. What are we spending in the coin of conscience to fit young men for the tremendous task we have given them?

Are we, through indolence, allowing their youthful vigor to be dissipated by disease, their youthful ideals to be contaminated by community conditions which defile all that is best in human nature and exalt that which is base?

Social hygiene is a program which attacks some of the oldest and ugliest of the ills that befall our society—venereal disease and sexual debasement. For many years, respectable people turned away in horror from consideration of such seamy problems . . . and the problems grew like rank weeds in an untended garden. That time of intentioned oblivion is now past, thank God. Those of us who yearn, with deep conscience, for the better world we know is within our grasp, attack these problems as we do others which beset our society today.

I have been asked, as Governor of Indiana, to share with you my impressions of where we in Indiana stand in regard to these problems—a kind of "State of the State" message. In order to obtain current factual data on these interrelated evils, I have turned to those of our state agencies which have responsibility for certain aspects of the problems.

VD is still with us

The picture which I glean from the information given me is not all black by any means. In fact, there is much progress to be noted from facts gathered by our Indiana State Board of Health. However, much remains to be done in controlling the spread of venereal disease.

Without any intent to be a scaremonger, I know facts indicate that the present status of venereal disease control is such that it has engendered

Their clear eyes
hold many questions.
Ambivalence
is not the answer.

a wave of ill-advised optimism or complacency. To examine the current situation in Indiana realistically, we can note that venereal disease remains a medical and social problem.

Now complacency may stem from the fact that our new drugs have formed a widely heralded defense battery against the inroads of these diseases. We are repeatedly cautioned that penicillin is not a panacea which will deliver us from the ravages of venereal diseases. In 1951, the Indiana State Medical Association and the State Board of Health devised a plan for the distribution of penicillin for the treatment of syphilis for the medically indigent. In the first eight months of the operation of this program, the State Board of Health distributed enough penicillin to treat over 2,000 cases of syphilis.

See no evil

Until the '30's, none of the venereal diseases could be mentioned publicly. This attitude, that the diseases were unmentionable, tended to induce a feeling that they, therefore, did not exist. Many people who would not admit to their existence were led innocently to the assumption that the venereal diseases were as far from their sphere as the planets.

Two examples right here in our own state will serve to indicate that this is specious reasoning. Not many months ago, the Indiana State Board of Health was notified of the existence of several cases of venereal disease in one community. Through the cooperation of local physicians and the citizens of this community, the State Board of Health interviewed many of these cases. During this investigation, some startling facts were revealed.

The Board of Health received notification that there were cases of syphilis in Illinois and that contacts of these cases had been reported in Indiana. The investigation made subsequent to this notification indicated that there were three cases of primary syphilis in this state arising as a direct result of the Illinois cases.

They played with fire

Early in 1952, the Board of Health was called upon in another locality to help in locating contacts among some young people in Indiana who were ill with a venereal disease. Investigation revealed that these young folks were 12 to 16. To check the spread of the disease, the local health officer, assisted by trained interviewers from the Board of Health, interviewed several girls.

One of these children, only 14 years old, named 32 sexual contacts. The time interval covered by these 32 contacts was approximately one month. Five additional girls were interviewed, and these six children named over 100 sexual contacts.

As a result of this investigation, the doctors in the area found and brought to treatment a number of cases of gonorrhea.

I am happy to report that this outbreak has been checked through the alertness and cooperative effort of the physicians and the health authorities. Recognizing the possible background of this outbreak, the State Board of Health and the citizens are planning an educational program designed to prevent the recurrence of such a situation.

Although the general trend of syphilis infections in Indiana follows the national pattern of a downward movement, I cannot say I have been told that the same is true for gonorrhea. In this latter disease, the trend in the state is upward.

In 1941, 352 cases of congenital syphilis were reported in Indiana. Ten years later, in 1951, 262 cases were reported. These are merely cold figures, but back of them lies the undeniable fact that in 1951 in Indiana 262 babies were born with syphilis which they had contracted in their innocence.

Case-finding

As the occurrence of syphilis decreases, the single and specific case is, of course, more difficult to locate. To locate cases of syphilis it is necessary to interview, to find contacts and to get both cases and contacts to their doctors. The busy practicing physician has but little time to devote to this time-consuming project.

The State Board of Health maintains a staff of trained interviewer-investigators. They interview no patient without prior consideration of the physician. Their concern is to get the individual—whether he be

Penicillin for 2000 cases.

a case or a contact—to the physician of his choice and so under treatment to prevent the spread of the disease. This can be done only when the physician who treats a case of syphilis reports that to his State Board of Health on the confidential form provided.

Then the Board of Health can, with the approval of the physician, locate the patient's contacts and get them under a doctor's care.

Hoosier Democrat in the Horatio Alger tradition. Former lawyer, editor, banker, state senator, lieutenant governor.

Governor Henry F. Schricker of Indiana

Thus it will be seen that this problem reverts directly to local civic consciousness. Your State Board of Health stands ready to offer its entire facilities to any community that recognizes the problem and wants to do something about it.

Now, as to the related problems with which we are concerned—commercialized prostitution and sexual delinquency—they are more difficult to report. Most of our Indiana cities abolished segregated, or "red-light," districts during World War II. This reform was carried through on a wave of patriotic concern for the health and moral welfare of our men in the service.

Most of our cities and towns, having rid themselves of the stigma of tolerated prostitution, have determinedly fought its return, and successfully. In some others, an insidious beginning has been made toward the re-establishment of tolerated houses of prostitution.

I presume that it is known to everyone present here that we have laws prohibiting such business enterprises. We have laws against gambling also, yet this vice flourishes where vigorous prosecution of the law is absent.

Gambling and prostitution

It is not surprising to anyone who gives more than casual consideration to the subject, to find that prostitution and gambling are often co-existent. The structure of law enforcement is like a dike—one leak, and the dike is weakened, and other cracks inevitably appear. Once these two evils creep into the body politic, they begin to feed each other.

Gambling spots and houses of prostitution, both being outside the law, operate in a furtive atmosphere which attracts persons with anti-social tendencies. Crimes of violence are often plotted in these holes of iniquity. The role of the prostitute as an informer for the enemy is part of military history.

Underworld forces are at work everywhere, attempting to stage a comeback for tolerated prostitution, for it is a very profitable business in itself.

Prostitution cannot exist without hush-money.

Open sesame to other evils

Furthermore, the house of prostitution opens up a constellation of subsidiary rackets, such as blackmail and extortion. It enables the dirty hands of the underworld to put hush-money into pockets of police and other law enforcement officers . . . for unlawful business cannot exist without the giving and taking of bribes.

It causes venereal disease rates to skyrocket, for the old fallacy that a promiscuous woman can be kept free of disease has long since been exploded by medical findings. What folly it is to spend our public funds for our progressive and successful program of venereal disease control and yet tolerate conditions which go far to nullify our progress in public health control!

There are apologists for the red-light districts. Well-meaning but ill-informed persons sometimes argue that the segregated district keeps all sexual vice within bounds, that the closing of a red-light district creates an increase in crimes of violence, in assaults and rape. This is not true, for careful studies made by the American Social Hygiene Association prove that whenever a red-light district is closed down the major as well as the petty crime rate decreases.

Our youth

More important than any of the above, however, is the moral deterioration of our young people which is encouraged by prostitution. Recently I read a newspaper article which described a teen-aged gang said to be blackmailing patrons of a house of prostitution in one of our Indiana cities. There is a lesson in that story for those with eyes to see it. A community which condones law violation, as represented by prostitution, is deliberately corrupting its youth.

The question of what kind of moral attitudes our young people are absorbing concerns us deeply, for the teen-agers of today will be the

fathers and mothers of the next generation. What kind of families will they found and rear? In the answer to that question lies our whole future, for the family is the foundation stone of all society.

Literally, these young people of today hold our fate in their hands. What are we doing to steady their hands and to guide their aspirations toward clean living and high thinking?

Let us try to analyze some of the forces which are molding the moral fiber of our young people today. We are bound to say that much of what the clear eye of youth sees today is negative. Such conditions as I have described above are certainly deleterious to moral and spiritual welfare.

As Governor of Indiana, I am deeply ashamed that in certain of our Indiana cities such conditions still prevail. I can decry them, but I neither personally nor in my official capacity can change them.

Good laws need good citizens

The resources of our state agencies for health and law enforcement are available to all, but state enforcement of our health and legal codes is not the answer. The state police have in the past raided numerous truck stops and trailer courts and put a stop to illicit activities in such places. But they will crop up again wherever local sentiment condones or tolerates conditions of this kind.

Another state agency which is helpful in maintaining decency and order is the Indiana Alcoholic Beverage Commission. Tavern owners or proprietors are subject to regulations as to the conduct of their business, and their licenses are revoked by the A. B. C. when the regulations are not complied with. One of the responsibilities put upon the tavern owner is to keep promiscuous and loose men and women out of his establishment.

There are in Indiana 80 excise officers of the A. B. C. to enforce this and other regulations, such as selling to minors, adhering to the legal closing hours and so forth. Almost 8,000 retail outlets dispense alcoholic beverages. It is apparent that with the best will in the world, 80 officers could not catch every violation on their routine trips of inspection. However, upon complaint of local citizens, immediate action can be taken against violators.

This highlights a truth known to all of us, that only in a police state can people be compelled to obey a law or dictum 100%. In a democracy, the pressures for conformity and obedience to the law come mainly from the determination of honest citizens to rear their families in a decent and law-abiding community—such people as you who are here tonight, who attend meetings of this sort motivated by a desire to be helpful in creating the kind of communities we want.

Delinquency, detection and divorce

We hear much these days about the deplorable morals of our young people, and there are some who would claim that sexual delinquency has mounted to an alarming degree.

Before we condemn, however, we might well ask if some of the reported increase is not due to the heightened and more enlightened work of the agencies which deal with the problem. As with physical disease, when a program of detection is stepped up, the reported rate of that disease climbs. If this is the case with the social disease of delinquency, we should be gratified, not alarmed, that our juvenile courts are finding and trying to straighten out these tangled young lives.

In seeking to rehabilitate these young people, modern probation work digs below the surface for causes. There we find, more often than not, the broken or the inadequate home.

Good parents are good ramparts.

Charles Boswell, chief probation officer of the Marion County Juvenile Court and a member of the Indianapolis Social Hygiene Association, has this to say: "In dealing with the juvenile sex offender, I see one factor which stands out in the causation pattern—the chief satisfaction these girls were getting from their escapades was simply—fellowship! It appeared that their families had failed them in filling their need for affection. We are seeing a return of the 'victory girl.'"

And J. Edgar Hoover, director of the Federal Bureau of Investigation, has written, "Delinquency is increased by parents who are too busy with their own pleasures to give sufficient time, companionship and interest to their children."

Careless parenthood and broken homes spawn only weak incompetents, not the strong defenders we need today!

In this connection, a look at divorce statistics is revealing. After a postwar drop in divorce proceedings, they are again climbing. In Marion County, for instance, there was an increase of 12% in divorces granted in 1951 over 1950.

This is a sad reflection on the uneasy time in which we live. Wage-earners are on the move again, drawn by the magnet of defense industries . . . the same magnet which takes mothers away from their homes

and into the factories. Thus we have social casualties as well as wounds incurred in warfare.

What will happen to the Hoosier family in this troubled era when the old familiar fabric of family life is so strained and torn?

From the *Christian Century* we take some heartening advice, "In these days of gathering gloom, there are four things we can do with our hands—wring them, fold them, put them in our pockets, or lay them on some job that needs to be done."

Through labor

The Indianapolis Social Hygiene Association has seen a job that needs to be done and has laid hands upon it. Continuing work for strengthened law enforcement and health education is bringing results, slowly but surely. Social hygiene, working with our churches and our schools on programs for family life education and counseling, seeks to draw back into the family the strength perhaps not needed in an easier day.

There is a part for all of us in this job of building our first line of defense—strong, clean communities and homes. Let us put our hearts into the job.

CREDITS

Department of Defense Photos, p. 241, 274.

Harvey Patteson & Son Photographers, courtesy of San Antonio Chamber of Commerce, p. 250.

Elicson Photographer, p. 252, 256.

John Rose Portraits, Hutchcraft Studio, p. 254.

Courtesy of San Antonio Chamber of Commerce, p. 259.

Conway Studios, N. Y., p. 266.

Polls Open . . . Brothels Close

San Antonio Breaks with Tradition

by Elizabeth McQuaid

Twisting and turning roguishly about the city, the San Antonio River scorns the adage about a straight line and follows in its own good time its traditional path to the sea.

So it has been with San Antonio's history. Never dull, always individual, it burgeoned from Indian beginnings, borrowed from the Spanish their culture and emerged from its frontier days into a period of unholy politics and laxity that, except for a wartime era of lily-whiteness, blazoned San Antonio across the nation as one of the three worst cities for toleration of open vice.

That is, until June 1, 1951. On that day a new set of officials was sworn in on a platform that pledged local governmental reform and the adoption of a new city charter providing for a council-manager form of government. In an incredibly short time a freshly organized police department was enforcing laws that had long lain dormant. Today, just about a year afterward, San Antonio's citizens are congratulating themselves on the "excellent" rating they have earned from the American Social Hygiene Association for wiping out vice.

The door to San Antonio's riotous past is padlocked as tightly as are the doors of her red-light district. No longer do the gay ladies of Metamoras Street beckon to many of the 100,000 servicemen based around the city. Prostitutes, panderers and narcotics peddlers, who only last year shook their heads in dismay at the closing order, have now deserted the town.

The dramatic closing of the "district"—swift, decisive though it was—came as the final step in a long, slow evolution in public thinking.

For generations

For generations San Antonio had complacently nursed the tradition of the wide-open town. Its citizens ignored the taxi drivers and bellboys who doubled as panderers, the good-time girls and other underworldlings who swarmed on the city, following the easy-money lure. Even newspapers froze into silence over San Antonio's prostitution and venereal disease.

If an occasional citizen did pause to consider prostitution, he condoned its evils with the old dodge—"It's necessary." How else could you handle servicemen surging into town, casting off the discipline of the base? How else protect your women?

Granted that open and flagrant prostitution had best be suppressed—grossly unrealistic notion—how could you dig out the entrenched political machine that oiled its wheels with profits from vice rackets?

No, the average citizen a few years ago shrugged his shoulders and went his way.

San Antonio was good enough for him, he thought, as he watched its river flowing quietly between green banks past palm and pecan trees. His city, proud of that river, dredged it to a rural freshness, arched it with 40 bridges.

He passed the Alamo, resting in its garden setting, thickly walled off from the city. Within lay the mementoes of Crockett, Bowie, Travis—heroes all. Overhead a winter sun warmed the town to a faultless 76 degrees.

A little farther away, ringing San Antonio in a half-circle, tranquil Franciscan missions retained the bare, clean flavor of the past. And much of San Antonio's past was good.

The cocoon was cracking

But above the missions planes roared, and on the outskirts of the city vast military bases mushroomed. Texans hurried through Alamo Plaza toward Joske's department store or, in the opposite direction, toward the massive post office building.

The past was still there. But it was being submerged in the present which, with its insistent social demands, would inevitably catch San Antonio up in its current.

True, the city had had its share of momentary reforms, concessions to political expediency, even one period of law enforcement that lasted

Families now occupy these one-time cribs.

as long as one man was in power. It had had its share, too, of incompetent politicians notable only for their vigorous pursuit of the unsavory dollar.

One energetic individual comes to mind. His "clean-up" of the prostitution district was literally that and nothing else. With mop and broom, new lineoleum and deodorant, he renovated the cribs—one-room shacks rented by prostitutes on the west side of town—and cut down VD rates about as effectively as if he had sprinkled around athletes' foot powder.

P. L. Anderson

Of a different caliber was the reform of wartime Police Commissioner P. L. Anderson. With brisk anecdote he'll tell you of his decision to close the district. One afternoon in a brief directive to his force, he closed the houses for the duration of his administration.

"That was no reform," he'll snap. "I'm no reformer. I merely enforced the law."

And that he did, until the madams and their retinue conceded that the heat was really on. "The heat wasn't on," says P. L., with a twinkle, "it was a permanent temperature."

For his service to the Armed Forces, he received a commendation from Secretary of War Stimson and a citation from General Wainwright.

Smilingly he recalls another "honor" he had previously received—a charter membership in the "Research Clinic of America"—the building where it was housed still flaunts these words in giant letters across its wall. Purporting to have a preventive and cure for syphilis, the head of the clinic hoodwinked the city for some time before his cure was found to be fraudulent.

"It was a genteel racket, set out nice-like," P. L. drawls.

Today he says of prostitution, "There's no sense in regulating a thing that's vicious. If it were just the lone girl by herself, maybe it could be looked upon as a human frailty. But with panderers and financial backing, it's such an ugly thing. . . ."

This is the opinion of a man who recalls the days when there were only 96,000 Texans in San Antonio. "They stood on their rights and whatever they did was right. Concerted endeavor was unthought of. VD and prostitution were accepted, a boy had his fling and went to Hot Springs."

By 1951 San Antonio's citizens had come a long way when they elected a new administration pledged to close a town that had burst wide open when P. L. no longer held office.

The resistless surge

This 1951 clean-up was no political whitewashing, no military expedient to lower VD rates, no one-man crusade. It was an upsurge of public indignation against corruption in government. It came about through the concerted effort of a governmental research expert, a citizen-supported, independent planning board, a citizens' political action committee, the American Social Hygiene Association, the clergy, the military, the police, the plain people of San Antonio.

One of the men behind this revolution is Edward G. Conroy, director of San Antonio's Bureau of Governmental Research, a scholarly man of tremendous tenacity. In recognition of his service for better municipal government, he recently received the "San Antonio Award for Civic Service for 1951" from the Citizens Committee for Council-Manager Government.

Edward G. Conroy

As far back as 1934, Conroy, as a public-spirited citizen, had dreamed of establishing a government research bureau in his native city and had begun to lay the groundwork for a career that would eventually reform that city's administrative framework.

His enlightened council-manager plan suffered an early defeat at the polls in 1940. The charter which he drafted twice suffered a like fate.

Lt. Col. George M. Roper

But today a charter basically the same as this original one is in force in San Antonio.

In the meantime Conroy met with advocates of the council-manager idea. He set out to impress upon local business leaders the need for a governmental research bureau if there was ever to be a long-range program of local governmental planning. His efforts bore fruit in 1948 when he was invited to establish a bureau.

Time to strike

At last circumstances, so often stubborn, began to play into his hands. The tinder that was to inflame public resentment to the point where it cast out the old commission plan of city government was a defunct public hospital, left unsupported by the city political machine.

By 1948 San Antonio was without a public hospital of any kind.

With Conroy and his friends agitating for municipal funds and with the mayor and his councilmen refusing them, the newspaper gleefully picked up the controversy. Public opinion swung over to Conroy's side.

The mayor, highly incensed over efforts to further the council-manager plan, hurled a challenge at the reform leaders to run a candidate for mayor. Hastily they put up a candidate—reluctant Jack White. Enthusiastic voters swept him into office on June 1, 1949, to head as hostile a council as a mayor ever faced. Within two years he was to lead a whole reform slate into office.

By 1951 Conroy had assisted in bringing dissident council-manager factions together and had sparked the organization of the Citizens Committee for Council-Manager Government.

At long last

In May of that year a complete slate of candidates, led by veteran Mayor White, faced the voters. Solidly behind them stood the League of Women Voters. Behind them were the informed citizens of San Antonio—no longer apathetic but sure of their cause. People like Rabbi David Jacobson; Mrs. Martha Johnson Zeck—indefatigable social hygiene

worker; Harold Kilpatrick—who got out a voter's guide for 25,000 churchgoers. Social Hygiene Day observances had spread the idea that a modern social outlook was a practical thing.

Behind them were the long years of work of the American Social Hygiene Association—with parents and police, military boards and professional agencies, with educators, lawyers and legislators. Genial Whitcomb Allen, ASHA's San Antonio representative, reviewed his backstage work over the years and wondered if it was enough to swing the election.

Paul M. Kinsie, head of ASHA's legal and social protection division, considered the election so crucial that he was on the scene to throw the weight of the association behind the reform movement.

Sensational was the impact of a $1000 paid political ad prepared by Conroy, with help from Kinsie, that appeared in every San Antonio newspaper shortly before the election. This blast, aimed at every voter who opened a newspaper, told citizens the truth about prostitution conditions in the city and laid the responsibility for San Antonio's reputation as a "racket-ridden, wide-open town" on lack of law enforcement by the incumbent police commissioner.

When the votes were counted, the old commissioners threw in the towel.

"The ASHA ad clinched it," said Allen jubilantly. It was the first time in San Antonio's history that any candidate or group was willing to make an issue of the prostitution situation.

The police shake-up

Most spirited of the immediate reforms after this election was the crackdown on the police department.

The new councilman and police commissioner, Lt. Col. George W. Roper, veteran of Corregidor and a political neophyte, organized the department along the lines recommended by a survey conducted for the Public Administration Service by Dean O. W. Wilson of the School of Criminology of the University of California.

"Those who were doing their job (in the police force) got my backing," Roper said. "Those who didn't had to go."

Not to dictate, but to organize was his purpose. For a first-hand grasp of the prostitution problem, he rode around in police cars, was solicited himself by women of the street. In three weeks, from June 8 to June 30, 1951, San Antonio became a closed town.

The racketeers did not scurry for cover without offering a few protests. One night Roper's daughter picked up the phone to hear a voice—"If you don't stop these raids we'll take a shot at you." She did not hesitate to reply, "Sorry, but there are five or six ahead of you."

A street-corner bar is a silent reminder of more roisterous days.

One change Roper made in arrest procedures permits a policeman to make an on-the-spot arrest if he sees a violation. In the old days a policeman had to call the vice squad before making an arrest.

Roper put Lt. R. D. Allen in charge of the vice squad, and that officer lost no time in clamping down on the vice interests. "Captain Allen (he was made chief of police by Roper in November, 1951) would have resigned if I had not fought the racketeers," Roper explained.

On October 2 the new council-manager charter was adopted by a two-to-one majority, and in the following month the new nine-member City Council was elected. On January 1 City Manager C. A. Harrell, selected by these reform councilmen, took office—a $30,000-a-year job—and said to his council, "I'll argue with you informally, but once the council has spoken, that will be the policy."

A new police chief

Texan-tall and quiet-spoken, Allen, who was reappointed chief of police by Harrell, reports that the closing of the district has cut down the number of murders and sex crimes, the cuttings, assaults and drunkenness once associated with prostitution activities. Even traffic fatalities have decreased from 53 in 1950 to 44 in 1951.

"Our population has increased in 10 years by almost 100,000 people, but our policemen are not so busy during the early hours of morning as they used to be."

Using a "stool" to get a prostitution arrest is not entrapment in San Antonio. Getting a conviction, however, is no easy matter, for it requires witnesses and proof of money paid. "Holding prostitutes, testing them—all this has a real nuisance value," says Allen.

"By attacking prostitution you make general police work easier," he adds. "Elimination of prostitution means elimination of much of the narcotics trade and many undesirable transients."

Alcohol does not flow freely

Taverns which once cornered a sizable portion of the vice business now eke out a modest profit from beer and wine sales under constant check by the police. No hard liquor can be sold legally in a tavern or eating establishment. Bulging hip pockets are *de rigueur* in the best night spots. But all alcoholic drinks do a Cinderella when midnight strikes, except in Saturday night's hour of grace.

Legitimate private clubs have lockers where members store their stocks of liquor. All kinds of bogus "private clubs" attempt this dodge and sell liquor after hours—until they're raided.

One tavern, ordered closed by the State Liquor Control Board on the recommendation of the police, remained open under an injunction. The police raided the place for operating as an open saloon and quarried over 300 patrons.

Using Col. Roper's file as a nucleus, the police now have a record for each of 2,500 establishments that sell beer and wine. Folders contain entries for every infraction. A separate card file shows when licenses are coming up for renewal. These files give the police all the information they need for making recommendations to the State Liquor Control Board for renewing or withholding licenses.

The vice squad's Sergeant Shaw points to an increase in prostitution arrests and reported gonorrhea infections during the new administration as proof that his squad is on its toes. "The higher figures are not evidence of worse conduct. They show vigorous police activity and enforcement," Sergeant Shaw emphasizes.

Out of a group of 418 women brought in, 30.6% were infected . . . 81 with gonorrhea, 47 with syphilis.

The military

Lt. Col. Albert Feldman, air provost marshal, of whom Col. Roper says, "He's doing a good job," is a young man of brisk, efficient manner. He handles an insistent telephone while he gives you a few pertinent facts. He tells you that when an off-limits restriction is slapped down on a tavern, the effect is catastrophic for that tavern. For San Antonio is dependent on the military. A tavern without servicemen is a tavern in the red—witness federal government payrolls of $100,000,000 a year for the San Antonio area, with the military providing the major portion.

Of 28 places off-limits, 20 were put under this restriction because of prostitution activities. The reputation of an owner is a pivotal factor,

one hotel never having been on limits in two years because its owner is a bad risk.

Col. Feldman cites the good record of service personnel in the city, revealed in the comparatively small number of arrests of servicemen during December, 1951—only 476 out of the thousands of men in the area. At that, 210 of these arrests were for minor offenses. Parents need not fear when their sons are sent to San Antonio's military bases.

A few stories told by Feldman reveal the scarcity of prostitutes in the city. A panderer successfully tried one trick several times until a vice squad plant caught up with him. Approaching a group of soldiers, he would ask if they wanted a prostitute. In a "let's go" mood, they would climb into his car and drive off to the assignation.

"Give me your money for safekeeping and I'll give you a receipt," offered the obliging go-between.

When the soldiers reached the house, only an old man greeted them. The car and its driver were out of sight.

Another device was for B-girls (girls employed by taverns to wheedle soldiers into buying drinks) to hand out keys to soldiers in return for $3. On one night 30 soldiers descended on a house, each with a key. The house was vacant.

Feldman says, "With the passing of prostitution and bootleg whiskey, legitimate business has improved and retail sales have increased. Taxes are now being paid that were never paid by prostitutes and their panderers."

The rate should be zero

In tracking down VD contacts, military authorities cooperate with the health department and the police. If a soldier is infected, he describes the girl in a confidential report which is sent from the post hospital to the local health department. VD investigators may enlist the help of the police, who keep an arrest file and a picture file of prostitutes. On finding a likely suspect, the police send the photograph to the hospital for the soldier's identification. Even incomplete reports are valuable, one supplying the information another lacks, both sometimes pointing to the same source.

Col. Robert C. Gaskill, of the Fourth Army Surgeon's Office, says that a contact interviewer training school is being considered for the Army. "The contact index is not good. To combat VD successfully, we must find infected contacts and bring them to treatment. We don't have VD under control. Many of the contacts are never found and they multiply infections."

Quadrangle, Ft. Sam Houston. The clock tower was once a watch tower.

He quotes Col. E. O. Sandlin, Fourth Army provost marshal, who once said, "There is no acceptable VD rate. Any VD is bad. The rate should be zero."

San Antonio's VD rate is not yet zero, but the aim is on that target. Anyway you look at it, the city has done a herculean house-cleaning in six months' time. It is much further ahead than a Texas resort city whose chief of police was indicted for income tax evasion and whose mayor believes that everything should be available and a person should be taught to avoid what is harmful. Families are reluctant to live in an atmosphere so inimical to family life, and business is on the downgrade.

San Antonio is now engaged in a tax reassessment program. Expected additional municipal revenue from increased and equalized property values, as well as from new sources of revenue made possible by the new charter, will be used to finance an ambitious public works program and to establish a public welfare program.

The problem of crowded, outmoded housing, coupled with the high tuberculosis rate of San Antonio's Latin-American population, presents a serious challenge to the health department. Jack Mullen of the Chamber of Commerce is optimistic about the ability of the Latin-American to hurdle his difficulties. He says education is the answer. Perhaps he's

right—one public school which had a 10% Latin-American enrollment 10 years ago now has a 90% Latin-American enrollment.

A distinctive air

To Latin-Americans San Antonio is the United States. To others it is not typically American. Not quite western, not quite tropical, not quite south-of-the-border, it has a hybrid charm of its own. Its population, 406,811 in 1950, is compounded of Negroes (9%), Latin-Americans (40%), and leisurely Anglo-Americans. Not all the women are comfortably casual, not all the men are tall, topped by creamy, outsize Stetsons—but the impression is there, and it is enough to lift the spirits of the outsider, to make him sense the presence of the not-too-distant ranches and wide-open spaces.

The lobby of the Gunter Hotel is Wall Street, Texas style. There a cattleman can conclude fabulous deals as he relaxes in an easy chair. The high-speed, time-clock pace of New York is largely missing. Even a business interview may stretch into two, three, four hours, with no one concerned about the time.

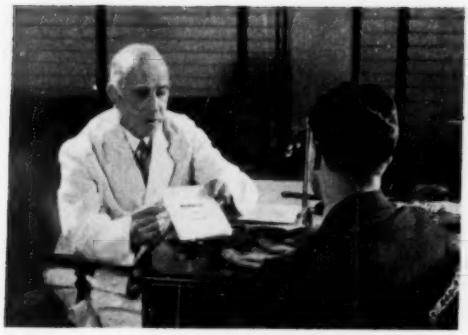
Every 5-and-10 has its spoonful of chili sauce on a hot dog. Every restaurant has its Mexican dish. Even Mexican beer has a special quality all its own.

Nor was there ever a theater like the Arneson, straddling the river, its grass-covered seats on one side, its stage on the other.

Skyscrapers cut San Antonio's skyline, and wealth from oil, livestock, cotton, flax and citrus fruits flows into the city. Trade with Mexico and Central America centers here. New families are pouring in, sure of the bigness of San Antonio's future, of the integrity of its officials, of the wholesomeness of its environment.

For their efforts to better their government, the citizens of San Antonio well deserve the All-American City Award they recently won. Here is proof that an informed people can clean up the most entrenched corruption. Here is proof that the long-term diversified efforts of the American Social Hygiene Association to strengthen family life through education and effective law enforcement can have a paralyzing effect on vice. Here is proof, too, that other American cities, including Mexican border towns, however unregenerate, can shake themselves loose from their racket ties and "go and do likewise."

San Antonio will tell them it's worth the effort.



The Clinician and Syphilis Control

by Bruce Webster, M.D.

A speech for Social Hygiene Day in Los Angeles April 23, 1952

During the last decade a non-toxic, readily administered agent—penicillin—has become available for the treatment of syphilis. It has simplified this treatment to an amazing degree and has revolutionized our concepts of the management of clinical syphilis. Eight years after its introduction it is important to examine the effect of this antibiotic on the control of syphilis in the United States.

For practical epidemiological purposes, syphilis is not one but two diseases. One of these, early syphilis (the first two years) represents an acute infection. The other, late syphilis, is a chronic disease of a crippling nature and represents a major public health problem.

Is syphilis declining in the United States since the advent of penicillin in 1943?

It would seem to the uninitiated that this would be a simple question to answer. As many of you know, it is now the subject of a heated controversy. An unqualified yes or no cannot be given to this question.

To attempt to answer it, one must consider not only the morbidity statistics concerning the increase of syphilis as a venereal disease, but one must take into account the amount of heart disease due to syphilis, the amount of central nervous system syphilis and many other factors. Due to the time lag in the development of these late manifestations, 15 to 20 years must elapse before the full impact of penicillin on these

factors can be determined. Further, it must be appreciated that in the five years prior to the introduction of penicillin, active syphilis control programs under federal and state sponsorship had been in effect.

- In 1949, it was estimated by the USPHS that 3,000,000 persons in the United States had syphilis.
- In 1951, 198,640 cases were reported by the various state health departments. This represents a consistent decline over the last five years.
- Approximately 14,000 cases of congenital syphilis occurred in 1949, although the infant mortality rate in that year was only one-fifth that of 1938.
- 13,000 individuals were known to have died of syphilis in 1949. This represents a 50% reduction in mortality from this disease in 10 years.

What does the physician have to offer the patient with syphilis at the present time?

The *patient* himself is primarily concerned with his chances of cure. The *community* is concerned with

- Reduction of infectivity
- Cleaning up of reservoirs of infection through epidemiological measures
- Prevention of late disabling complications which will become a drain on municipal funds.

Early, infectious syphilis

As a beginning, let us consider only early, infectious syphilis.

In 1945, 5,146 cases of infectious syphilis were reported in New York City. In 1949 only 2,218 cases were reported. Does this represent the true picture of the incidence of the disease? Probably not.

In 1945, arsenic and bismuth were still the mainstay of the treatment of syphilis in New York. Technical difficulties and the cost of administration sent most patients to a hospital or city clinic for their treatment. As a result, they were promptly reported to the city health department.

By 1949 the picture had changed greatly. Penicillin was readily available and was cheap. Further, it could be administered by any physician. Accordingly, syphilis became a disease which the neighborhood physician could treat himself. It was no longer necessary to refer it to a specialty clinic. Sometimes he was not too particular about diagnosis. After all, penicillin helped most venereal diseases. Similarly, either through lack of a consciousness of community health responsibility or in an effort to

"give his patient a break," he called it a "strain" or a "hair-cut" and did not report it to the health department.

How much of the apparent decline of infectious syphilis can be thus accounted for is impossible to determine.

In 1943, when Mahoney demonstrated the therapeutic value of penicillin in syphilis, a group of individuals set up a cooperative study to determine its effectiveness in terms of dosage and cure rates. Thirty-six institutions cooperated. A central committee distributed dosage schedules, and the results of follow-up were evaluated by a central biostatistical unit in Baltimore. As a result of this study—which, by the way, has established a model of procedure for other experimental therapeutic agents—ineffective dosage schedules were quickly detected and abandoned.

The experiment was terminated in 1949 and the analysis of results completed in 1951.

As a result of this study, eight years after the introduction of penicillin we are able to give to an individual patient with infectious syphilis a biostatistically sound estimate of his chances of cure with a given schedule of treatment. This is something we could not do for the arsenicals 30 years after the introduction of arsphenamine.

Certain aspects of this report are of fundamental interest:

- Up to a total dosage of 2.4 million units of penicillin an improvement in results followed an increase in dosage. There was no evidence that increase in dosage beyond this point served to reduce the failure rate.
- Durations of 4, 7.5 and 15 days showed similar results, other variables being equal. Below four days there was an increase in failure rate.
- Seronegative primary syphilis had the highest cure rate. High titre secondary syphilis, the lowest.
- Clinical relapse, if it occurred, took place within the first year. After that, evidence of "failure" meant infection.

With a penicillin dosage of 2.4 million units administered to infectious syphilis over an eight-day period, the cumulative failure rate due to clinical relapse and/or reinfection was nine per cent. An exact estimate of how many of these cases were reinfection is impossible to determine. On clinical and epidemiological evidence, several observers have estimated that 75% represent reinfection.

Thus it would appear that a patient with infectious syphilis, adequately treated with penicillin, has at least a 95% chance of cure, provided he does not get reinfected.

14,000 cases of congenital syphilis occurred in 1949.

Dosage schedules in early syphilis

Although the cooperative study on the penicillin treatment of early syphilis has shown that the optimum treatment schedule with the lowest failure rate is 2.4 million units over eight days, clinicians are constantly endeavoring to shorten the time-dose relationship. From a public health viewpoint, the ideal therapy is one which can be given at one visit.

There is pharmacologic evidence to support the idea of one massive dose as early as possible, since the spirochetes appear to be more vulnerable to such a concentration early in the disease. Two and four-tenths million units given in a single injection had a cumulative failure rate of 10% at the end of two and one-half years. The same amount of penicillin given in two doses four days apart had a failure rate of eight per cent. Given seven days apart, this rose to 19%. Thus it would seem that there must be a high concentration of penicillin maintained for approximately four days, either by repeated injection or a suitable action-delaying medium which may be in the offing.

The slow growth of the spirochete with a day-life of approximately 30 hours would seem to make apparent the fact that a single daily injection is adequate in any treatment schedule for syphilis, rather than the hourly or three-hourly regimes which were used formerly.

What of the five per cent failures? There is disagreement among authorities concerning the cause of these. Many feel that they all represent reinfections or superinfections. Whatever the cause, there is ample evidence that they can be retreated successfully with penicillin, either on the same or an increased dosage schedule.

Reinfection

Although reinfection in syphilis has been recognized for many years, the criteria for its diagnosis were formerly so rigid that it was rarely

made. Shortly after the introduction of the rapid treatment of syphilis with antibiotics, patients began presenting themselves—within a few weeks of the completion of treatment—with a new syphilitic lesion, usually in a different site from the previous one. Epidemiological investigation might reveal recent contact with infectious syphilis.

As these cases became more frequent, it became apparent that we were dealing with a reinfection and not a recurrence of the previous one. Was this apparently new phenomenon due to the fact that penicillin did not allow the individual to develop immunity, whereas the older, slower methods of therapy did?

The explanation is probably much simpler. Being infected with syphilis probably does not materially alter the sexual habits of the average individual. Accordingly, his exposure rate is the same before and after infection. However, with the older heavy metal treatment he returned to the clinic each week and received his weekly injection of arsenic, which acted, in reality, as a prophylaxis, destroying any spirochetes which he may have taken on during the week.

In addition to this, most clinicians now realize that in the past they labeled many cases recurrences which were reinfections. The differential diagnosis can only be made by combined clinical, serological and epidemiological evidence. Nevertheless, the principles of reinfection and superinfection have been established both in man and the experimental animal, not only in early but in late syphilis.

This phenomenon plays an important role in the evaluation of penicillin therapy. Does a second infection in a penicillin-treated individual represent a failure of the first treatment or is it an entirely new infection?

Prophylaxis

The problem of the penicillin prophylaxis of syphilis is one which is being forced on the attention of the clinician whether he be in private or public health practice.

With improved methods of contact investigation, it is not unusual for an apparently healthy individual to be notified by an investigator that he has been exposed to infectious syphilis. Schock has shown that if such individuals are given penicillin therapy they will not develop syphilis, whereas if they are allowed to go untreated at least 60% will show evidence of infection. Further, they may infect others before they are brought under therapy. The fact is now well established that relatively small amounts of penicillin will destroy the spirochetes in this preclinical invasion stage. Despite certain obvious disadvantages from a sociological viewpoint, it would seem that a conscientious physician would find it difficult to refuse such an individual treatment.

McGill University graduate.
Associate Professor of Medicine,
Cornell University Medical College.
Colonel, MC, USA, 1942–1946.
Consultant, U. S. Public Health Service.

Bruce Peck Webster, M.D.

To go one step further, there is the problem of the individual who thinks he may have been exposed to infectious syphilis and presents himself to his doctor the next day asking for prophylactic penicillin. What is to be done about this individual? At the present time opinion is divided among conservative physicians as to whether or not he should receive prophylactic treatment. However, if he does not receive it from his own physician there is always the less conscientious one from whom it can be obtained. If such an individual is treated, it should be done on the unconditional promise that he will submit to serologic follow-up for at least six months.

The dosage of penicillin required for such prophylactic treatment is at present the subject of investigation by various individuals. The newest action-delaying forms of penicillin offer much hope in this regard.

Impact of penicillin on late syphilis

As was stated earlier, syphilis is in reality two diseases, an early infectious one and a later one with crippling systemic manifestations.

In between these two stages, there is the period of *latent syphilis*, which is fundamentally a public health problem. Manifesting itself as it does only by a positive serologic test for syphilis, it is detected only when such a test is taken. If it is not detected, at least 15% will develop serious manifestations of the disease sometime later in life.

Although the United States has the most extensive case-finding mechanisms in the world, undetected latent syphilis is still a major problem. It is estimated that 80,000 cases go undetected annually. The masking of early syphilis by the penicillin treatment of gonorrhea without adequate serologic follow-up may further increase this number.

If we are to prevent the development of cardiovascular or central nervous system syphilis—and we *can* prevent it by the adequate treatment of latent syphilis—we must continue and increase our case-finding through premarital, preemployment and the various other means of serologic testing. In this connection, perhaps we have neglected the education of the family doctor. He should be encouraged to perform a serologic test for syphilis

on every new patient and at regular intervals on his old ones. Every hospital or clinic admission should include such a test.

Only by such nation-wide extensions of our serologic testing can latent syphilis be detected.

What can we do about latent syphilis once it is discovered? The first step is to establish the fact that the disease is latent. A careful physical examination including a chest x-ray and spinal fluid examination must be done before the patient can be told that his disease is still latent.

Our knowledge of the effect of penicillin treatment in latent syphilis is largely by analogy of what we know it will do in early and in central nervous system syphilis. This is supplemented by reports of the treatment of early latent syphilis in which from 50% to 60% of the cases became seronegative or had appreciable drops in titre following treatment. The remainder, as would be expected, remained seroresistant. The minimal dosage of penicillin for the treatment of latent syphilis would seem to be four million units given over a period of 12 to 14 days. In the light of our present knowledge, such a schedule should protect the patient with latent syphilis against the development of central nervous system or cardiovascular involvement.

Central nervous system syphilis

In 1943 the skeptics felt that penicillin offered little to the patient with central nervous system syphilis. By 1946 there was general agreement that it would accomplish as much as heavy metal therapy and in a much shorter time. However, there were still many advocates of concurrent fever treatment.

Gradually the confusion has cleared and there is almost universal agreement that four million or more units of penicillin given over 14 days is adequate treatment for asymptomatic neurosyphilis, acute syphilitic meningitis and meningovascular syphilis. There are still a few who maintain that the degenerative forms of the disease—tabes, paresis and primary optic atrophy—require concurrent penicillin and malaria therapy. It would seem, however, that there is mounting evidence to indicate that penicillin alone is adequate in these forms of the disease.

Too much stress cannot be placed on the early diagnosis of central nervous system syphilis. Every patient in whom a diagnosis of late or latent syphilis is made should have a spinal fluid examination. The detection and treatment of asymptomatic central nervous system syphilis will completely eradicate tabes, paresis and primary optic atrophy, thereby relieving the taxpayer of the burden of support of these people.

In this connection, I am reminded of an historical fact. Late in the 15th century the city of Frankfort offered free treatment with mercury to persons with syphilis and, as an inducement, made them tax-exempt

during the treatment period. Such a case-finding method might prove valuable today.

Cardiovascular syphilis

Approximately 15% of all early syphilitics, if untreated, will develop cardiovascular lesions. Although it is to be hoped that with the adequate therapy of early syphilis and the detection and treatment of latent syphilis there will be a decrease in the amount of this form of the disease, it is likely to be a sizable public health problem for some time to come.

The detection of early cardiovascular syphilis in any clinic is in direct ratio to the training and interest of the physicians in that clinic. Every late syphilitic should have a careful physical examination and chest x-ray. The aim should be the detection of early, uncomplicated aortitis before it has gone on to aortic insufficiency or aneurysm.

Once the disease is detected, the patient should receive not only specific treatment for his syphilis, but should be evaluated as any other cardiac patient in terms of workload and his cardiac reserve. Here the social worker and public health nurse are indispensable.

Recent studies have shown that specific penicillin therapy brings about a change in the aorta, rendering the syphilitic process inactive. A biostatistical analysis of 1,200 cases of syphilitic aortic insufficiency from Johns Hopkins and the New York Hospital is now in progress in an effort to determine the natural history of the disease. It is already apparent that the adequately treated, properly managed patient with uncomplicated aortitis or syphilitic aortic insufficiency, even after the onset of failure, has a much better chance of survival than was formerly believed.

The teaching of syphilis

Fifteen years ago a prominent authority on syphilis was accustomed to tell his students in medical school that the diagnosis and treatment of syphilis was a complicated procedure requiring the facilities and the knowledge of a specialist and that they had best refer their patients to him. Thus he disposed of the treatment of syphilis.

Ridiculous as such a statement was, it was not without truth. The administration of old arsphenamine was not to be undertaken lightly. Accordingly, the average physician did refer such cases to a clinic or to the specialist.

With the introduction of penicillin therapy, this picture has changed. Any doctor can administer it with safety. A marked decrease in the cases of syphilis reporting to clinics has resulted. This can only mean that the general practitioner is treating the disease in his office, and this is as it should be. Such a broadening of the base of treatment

sources is bound to result in increased control. However, it places a serious obligation on medical schools and federal, state and county venereal disease control agencies.

If every physician is to treat syphilis, he must be familiar with the latest information, both in diagnosis and treatment.

To equip the undergraduate physician with this knowledge is the responsibility of the medical schools. How to do this in the face of rapidly decreasing clinical material is a problem of some concern to many of us. However, it is obvious that, more than ever before, the medical student must be equipped to control syphilis.

The education of the physician who is already practicing is the problem of the various echelons of the health department. Renewed efforts must be made to make physicians syphilis-conscious. They must be provided with facilities for the darkfield and serodiagnosis of syphilis. They must be acquainted with current treatment schedules and educated in contact investigation and follow-up.

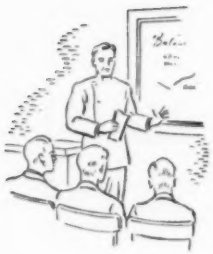
The patient, by seeking the aid of such physicians, has enrolled them in the cause of syphilis control. It is up to health agencies to welcome them into the ranks and equip them to do their job if necessary.

Conclusion

I have attempted to outline the common problems in the control of syphilis which confront the clinician, whether he be in private or public health practice. Coincidentally, one must consider the impact of penicillin on the management of these problems.

In only two decades in the history of mankind has syphilis been dealt a severe blow. The first was the period between 1905 and 1910 during which the spirochete was isolated, the Wassermann reaction developed and arsphenamine introduced. The second was the present one in which penicillin was introduced as a safe, rapid form of therapy. One must not neglect to mention, in addition, the strides which have been made in case-finding and the early diagnosis of late forms of the disease during the last 10 years.

What does the future hold? The indications are that we can expect more, and perhaps more powerful, antibiotics or improved action-delaying media, so that the dream of a single injection treatment may not be too far removed. The cultivation of the spirochete and possible immunization to it is still more remote. In the meantime, it behooves us to continue our efforts at control for the sake of this and future generations.



JUMPING JURISDICTIONAL LINES

Case-finding steps outside the state

by Adele C. Shepard, M.D.

New Jersey has been successful in lowering its syphilis incidence rates, and it is now in the lower half among the states in attack rates per 100,000 population. To maintain and improve this control, however, more concentrated activity is necessary. The present nation-wide defense program has caused a significant dislocation of population in the state, and there has been a sharp increase in the number of young people separated from their home influences.

In addition to being highly industrialized (New Jersey has more factory workers per square mile than any other industrial state), the state has the largest concentration of military personnel on the eastern seaboard, and even greater concentrations are anticipated. The migrant agricultural labor force in the state constitutes a roving population in excess of 50,000 annually. Moreover, there are hundreds of thousands of transient workers and visitors associated with the numerous resorts and seaside recreational areas.

Military-civilian exchange of data

As early as November of 1948, the Army, Navy and Air Force, Coast Guard, Public Health Service and Association of State and Territorial Health Officers reviewed previous agreements and again expressed their interest in an agreement for the control of venereal diseases.

These organizations were particularly concerned about problems of prevention and control created by the anticipated increase in Armed Forces personnel and by the mounting number of individuals entering defense industries. The necessity for collecting and exchanging information about civilian contacts of infected military personnel and military contacts of

civilians with venereal disease infections was reemphasized in this agreement. It was hoped in this manner to bring to treatment more quickly those contacts who needed treatment.

Early case-finding by investigation of contacts is the most important aspect of the venereal disease control program. Until we can break the case-contact-case chain, infections continue to be spread in an ever-widening circle.

Contact investigation is increasingly difficult under circumstances such as exist in New Jersey today where the nature of the venereal disease contact generally is quite different from the contact during periods of population stability. The encounter today is frequently a chance meeting with little, if any, exchange of personal information between sexual partners. Any information which may be given is often fictitious, because the type of person named as a pick-up or prostitute prefers to remain anonymous. A soldier on leave in a strange city may not even remember the name or location of the bar where he met his pick-up.

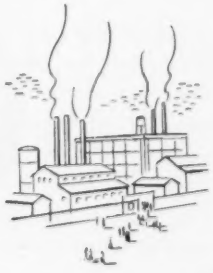
The usual methods of interviewing, investigation and routine channeling of venereal disease contact information are inadequate to cope with this problem of incomplete information about transient contacts and suspects.

Federal assistance

Recognizing the dangers and difficulties inherent in such a situation, the New Jersey State Health Department—beginning in July of 1951—obtained federal assistance in the development of a project aimed at maintaining an adequate venereal disease case-finding program.

The plan was to assign trained interviewer-investigators to military installations and recreation areas frequented by military personnel. They were to be given authority to work with both civilian and military populations, since the control problems of the two groups are closely interrelated.

New Jersey's Bureau of Venereal Disease Control and the United States Public Health Service screened approximately 60 applicants to fill the five



New Jersey — a mecca for industrial workers.

positions in the program. Of the men chosen, one was an experienced Public Health Service employee transferred from another area, and four were trainees. All had college degrees, a prerequisite for the positions. Men were selected because it was felt that male investigators were preferable for locating contacts under the circumstances noted above.

Special training

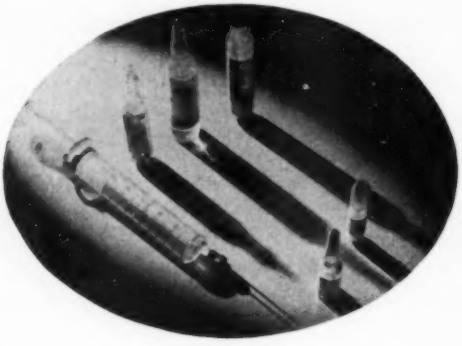
Orientation of the investigators began in the state health department, where they learned about the organization and program of the department—the various divisions and bureaus and the nature of their work, the functions of district health offices and local health departments, and the relationships of these groups to each other.

The four trainees received instruction in the principles, history and development of venereal disease control, in the medical and public health aspects of the problem, and in the purposes and interpretation of records and reports. Another important part of their instruction dealt with public relations, a vital aspect of this program where the investigators were to be in contact with various health departments, military establishments, private physicians, community organizations and the general public.

Upon completion of this orientation program, the men were sent for courses in interviewing techniques to schools designed for this purpose and located in Alto, Ga., and in Norfolk, Va. When they returned to New Jersey they were given field training in investigative techniques by a person with considerable experience and skill in the application of these techniques.

Only then did the Bureau of Venereal Disease Control feel that they were ready for field assignment.

By September of 1951 the men were ready for duty and were assigned to five areas in the state which had expressed a need for the assistance these men were prepared to render. Requests were based on an appraisal



They learned the answers to VD control.

M.D. degree from Northwestern.
M.P.H. degree from Columbia.
Chief, VD Control Program,
N. J. State Department of Health.

Adele C. Shepard, M.D.

of their real and potential venereal disease case-finding problems. The five investigators were assigned by the bureau through district health offices to Newark, Camden, Atlantic City, Camp Kilmer, Fort Monmouth, and their surrounding areas, and each became, in effect, a local health department worker . . . with one major difference.

Crossing jurisdictional lines

Agreements were made with the responsible authorities in the military installations, in the health departments of New York City and Philadelphia, and in various municipal health departments in New Jersey whereby the investigators were permitted to cross jurisdictional lines to obtain more complete contact information from military personnel and to locate out-of-state civilian contacts as well as suspects in other areas of New Jersey.

The health authorities, of course, were to be informed of all investigative activity in progress in their territories. Such coverage of localities outside the assigned area had been used to a limited degree in earlier control programs but was extended significantly in the present study.

Crossing of jurisdictional lines may involve obtaining the permission of the commanding officer at a military base to allow an infected soldier to accompany the investigator to another area to trace a contact. Fort Dix, a large army post near Trenton, had sufficient personnel so that the assignment of a man from the health department investigative staff was not necessary, but a close working relationship was established between the bureau and the post's preventive medicine officer.

From Fort Dix to Philadelphia

As an example, the health program representative of the Public Health Service attached to the New Jersey State Department of Health was requested to reinterview an enlisted man at Fort Dix who had given fictitious information about his contacts. The soldier vaguely described two exposures in a house of prostitution "somewhere in Philadelphia," but he could not give the address.

Permission to transport the soldier to Philadelphia was granted, and the New Jersey investigator arranged to meet with the senior investigator

New Jersey — center for service personnel.

of Philadelphia. The soldier was taken to the bus terminal near Broad and Market, the place at which he had entered the city on his previous visit. The route taken by the GI was retraced from that point. Some 50 blocks and 30 minutes later he identified the house where his exposures had occurred.

Six prostitutes were found in this establishment and all were examined in Philadelphia clinics. Their infections totaled six cases of gonorrhea, one case of chancroid and two cases of previously treated syphilis.

A similar incident involved a corporal stationed at Camp Kilmer who was diagnosed as having infectious syphilis. He knew his contact by her first name only, but was permitted to accompany the investigator to a Times Square bar where he had met the girl. Fortunately, she appeared and the soldier pointed her out to the investigator, who was then able to obtain her full name and address. Arrangements were made for her to attend a New York City clinic the next morning.

Their interviews are productive

On the first day of his assignment to Fort Monmouth the health department investigator was requested by the physician in the station hospital to reinterview an enlisted man who had given no usable information

about his sexual contacts. More than an hour later he terminated his interview with the soldier. Net result—eight sexual contacts not previously given were named and described.

In addition to his activities at the military installation, this investigator also works in a number of venereal disease clinics in Monmouth County. For many years the county had been making a substantial appropriation for venereal disease control, but, believing that the program was no longer needed, it had eliminated the amount required for this program from its latest budget plan. After existing local problems were pointed out, however, by the intensive case-finding activity on the part of the investigator assigned to this area, the appropriation was restored.

Atlantic City, New Jersey's renowned resort, also proved to be a fertile field for case-finding. The investigator serving this locality immediately began operations through the city's venereal disease clinic. It was critically understaffed and averaged only about 50 clinic patients per month.

After four months of intensive case-finding, the monthly clinic attendance reached the 300 mark. Plans are now under way to integrate the venereal disease clinic with the outpatient services of the Atlantic City Hospital so that more adequate diagnostic and treatment services will be available.

Preliminary results are promising

Complete evaluation of performance by the investigators will not be available for some months. Monthly evaluation of investigative activity indicates, however, that approximately 76% of the suspects investigated were brought to examination. This percentage is well above ordinary expectations. Of 595 individuals examined, 271 needed treatment. These results are gratifying.

It is my feeling that our selected college-trained investigators have achieved outstanding success in the location of individuals suspected of having venereal disease, thereby increasing the number of infections detected. They have established effective working relationships between military and civilian venereal disease programs and have provided, in addition, valuable assistance to local health departments.

Six months have elapsed since the beginning of active field duty in this new military-civilian effort in venereal disease control in New Jersey. Statements regarding results to date, therefore, can be considered in the nature of a preliminary report only, but we believe the project gives sufficient promise of future success to warrant its continuing expansion.

Great hope is placed upon this case-finding approach to keep the New Jersey venereal disease attack rate at its present low level during this period of military and industrial mobilization.

To Ernest Boyd MacNaughton

Engineer, pioneer builder and organizer, financier, civic leader, educator, patron of the arts, philanthropist

Who as a young man was one of a courageous group that pioneered the social hygiene movement in Oregon

Who from his great store of knowledge of men and affairs wisely counseled our leaders

Who led his fellow citizens in generous support of our Association

Who strengthened the national social hygiene movement by serving as our vice-president

The American Social Hygiene Association is proud to award in 1952

WILLIAM FREEMAN SNOW AWARD
FOR DISTINGUISHED SERVICE TO HUMANITY

Mr. MacNaughton's Acceptance

Why was I chosen to receive the William Freeman Snow Medal for distinguished service to humanity? In other years men and women of such eminence as General Pershing, Dr. Ray Lyman Wilbur and Sir Sidney West Harris have received the Snow medal. I think the American Social Hygiene Association decided to award the medal to me because it wanted, through me, to pay tribute to the west coast's pioneering work in the social hygiene field.

In naming me the 1952 Snow medalist, the Association is undoubtedly thinking of me as a symbol of all those hundreds of people of the west coast who have contributed over the years to the control of social disorders and to the growth of education for family life, marriage and parenthood.

In the 40 years since the inception of the social hygiene movement, we people of the west coast have come far in this field. We insist that young men and women have blood tests before we permit them to marry and establish families. Through our homes and our churches, our youth groups and schools, we try to prepare young people for the joys and responsibilities of successful marriage and happy parenthood.

We have not yet finished our social hygiene job here on the west coast. There are still things to do. We still must convince many people that penicillin is not the final answer. Penicillin cures . . . but it doesn't find disease. Penicillin cures . . . but it doesn't prevent the misconduct which transmits disease. We can't substitute medicine for morals.

If you could give your son or daughter only one gift for a happy life, what would it be? Money? Brains? Good looks? Character? The thoughtful parent would certainly say character.

This, then, is the big aim of the social hygiene movement . . . to help parents, teachers, ministers and others who guide young people to give our youngsters that precious gift, that priceless heritage . . . clean blood and good character.

Newell Walter Edson

HONORARY LIFE MEMBERSHIP • 1952

A New Englander by birth and inclination, Newell Edson well exemplifies the views of another son of the rockbound coast who said in *The Education of Henry Adams,* "a teacher affects eternity; he can never tell where his influence stops."

Although for 30 years Mr. Edson has borne officially such labels as "welfare worker," "social hygiene field representative" and "social hygiene executive" and has well fulfilled the tasks concerned, he is essentially and forever in the ranks of those who "gladly learn and teach" and his works go marching on.

His influence through his writings, his lectures for students, teachers and parents, his personal-guidance conferences and his citizenship can hardly be measured in set terms. Rather, these efforts are like pebbles dropped in a pool whose borders are without limit and whose ripples will continue to spread as long as people seek for the help social hygiene can give.

Newell Edson was set in the "learn and teach" pattern some years before he found the social hygiene field henceforth his pasture. Born in Portland, Me., in 1881, he attended public schools there, then entered Harvard College, graduating with a B.A. in 1903. For two years he was English instructor at the University of Maine, and then for 16 years served as teacher and principal in various well-known boys' schools such as the Hill School, Pottstown, Pa., the Huntington School, Boston, and the McBurney School, New York City.

During this time he studied at Harvard, Yale and Columbia, specializing in education and psychology.

In 1920 he became an educational assistant in the U. S. Public Health Service's venereal disease division and a new future began to open which promised to utilize all his previous training and experience. In 1921 he joined the staff of the American Social Hygiene Association to work in the new Division of Educational Measures. Since that time, except for a brief period of social service, Mr. Edson has been counted among the country's most active social hygiene workers.

At the time Mr. Edson came to ASHA, the organization was just swinging into its broad postwar program. The Division of Educational Measures was breaking ground towards the long-range objectives then stated as an essential part of the "four-fold American plan" and today recognized as the underlying foundation for all social hygiene progress. The measures proposed sought

> "to provide sound character-training in childhood and youth, as a major influence in the promotion of high moral standards of sex conduct; to furnish accurate and suitable sex instruction as a part of human relations education and of training for marriage and parenthood."

Under the direction of Dr. William F. Snow and Dr. Max J. Exner, with the guidance of Dr. Thomas W. Galloway and Mrs. Anna Garlin Spencer, Mr. Edson was soon busy with training courses for teachers, institutes and lecture courses for parents, students and the general public, and writings for all these audiences. For 11 years he was chairman of the National Congress of Parents and Teachers' social hygiene committee, conducting conferences at seven national and some 30 state PTA conventions.

He has given courses in important American colleges and universities in nearly every state, discussing such topics as "The Theory and Practice of Sex Education"; "Social Hygiene and Sex Education"; "Education for Marriage and Parenthood" and "Education for Marriage and Family Life."

Out of his experience with such audiences and particularly from his expert handling of the lively question periods which invariably follow his talks, Mr. Edson has come to know well the kind of information and guidance wanted and needed by the public, especially by young people. A number of enduringly useful and popular pamphlets—many of these have been published by ASHA—have resulted. Among them are *From Boy to Man*, for adolescent boys; *Love in the Making*, a talk for older boys, and *Choosing a Home Partner*, for young men and women.

He is also the author of several publications used widely by professional social hygiene workers, such as "The Status of Sex Education in

High Schools"; "Cooperation of Home and School in Guiding Boy-Girl Conduct" and "Discussion Outlines on Love, Courtship and Marriage." He has often contributed to educational magazines.

From 1932 to 1934 Mr. Edson was director of ASHA's division of education and family relationships. Shortly after this, when it appeared that ASHA's main effort was needed to back up Surgeon General Parran's nation-wide drive against syphilis, Mr. Edson served as field representative for ASHA's National Anti-Syphilis Committee.

In 1938 he became executive secretary of the Erie (Pa.) Social Hygiene Association.

Like most successful executives Mr. Edson owes much of that success to a steadily cooperative and understanding helpmate. Shortly after his graduation from Harvard he married Miss Jennie Ethylyn Boody of Portland, Me., alumna of Massachusetts Normal Art School and instructor of art in Framingham (Mass.) State Teachers College. They have one son, Dr. John N. Edson, practicing cardiologist in Brooklyn, N. Y., and two grandchildren, John Richard and Joanne Newell.

It is a satisfaction and pleasure to the Committee on Awards to confer this Honorary Life Membership upon Newell Walter Edson, a social hygiene pioneer of valuable and lasting attainments.

John Hall

HONORARY LIFE MEMBERSHIP • 1952

"One of the rollingest stones that ever bounced along the public health highway," John Hall says of himself. Others call him "Honest John" or "Johnny-on-the-Spot."

For the American Social Hygiene Association he has done more jobs in more places than any of us. More times than even he can remember he has resigned and retired. His most recent "final" retirement occurred last fall after a strenuous summer as an ASHA field representative. No one will be surprised, however, to hear that he has just returned from Alaska, where he went on a social hygiene mission of special importance to national defense.

John Hall was born in the old village of Freehold, N. J., which he still calls home. Following 1912 when he received a degree in sanitary engineering from the Massachusetts Institute of Technology, he worked with the state health departments of Massachusetts, Maryland and his home state.

He married Lillie Worden on April 24, 1915, and one child, a daughter, was born to them. Mr. Hall and his wife have three grandchildren, one brand new. This situation, he says, calls for full utilization of all his social hygiene experience.

World War I saw Mr. Hall an Army Sanitary Corps captain in France, where after the Armistice he studied at the Sorbonne and gave the Republic a thorough inspection. Business experience came next—as purchasing agent for a New York cloth concern, as salesman for a chemical company, as cashier in his hometown bank, and as an architect and builder there.

But interest in public service and a flair for propaganda soon brought him back to the public health field. As editor and promoter of a Health Bulletin Service initiated by the American Public Health Association and later taken over by the New Jersey Health and Sanitary Association—of which he is long-time secretary—Mr. Hall pioneered in the production and distribution of simple, readable articles on many phases of public health. Published in the NJH&SA's *Health Progress* and subsidized as a health education experiment by the New Jersey State Board of Health, these texts were used widely by local health departments and health workers.

Mr. Hall's interest in social hygiene started in 1916 when as health officer of East Orange, N. J., he became a member of the Oranges' VD Control Committee. This organization, the clinic it operated and the public information materials it produced were models for similar efforts 20 years later.

New Jersey's health department kept its VD control division intact through the postwar years and when the 1936 upsurge of VD activity started, the New Jersey program was promptly stepped up and John Hall was called in. His flair for public education was put to use, and the posters and pamphlets he prepared and meetings he helped to promote got favorable mention across the country.

At the same time he was calling the attention of professional workers to New Jersey's program by articles in the JOURNAL OF SOCIAL HYGIENE.

World War II saw Mr. Hall offering his services where they might be of most value. The U. S. Public Health Service placed him in charge of sanitation for Nevada's important Las Vegas area. Later he spent a year in similar work for Alaska's health department.

He left Alaska to join ASHA's staff, which since 1939 had been doing its part to build military and industrial health and morale by providing VD educational materials for the Army and Navy and by stimulating communities to provide clean community conditions for servicemen and defense workers.

Clean-ups and cross-country tours

The important job of cleaning out prostitution nests near military areas—many of them strongly intrenched and preying on soldiers and sailors—challenged Mr. Hall and he joined the ASHA field staff, first in the southwest, then in the middle-eastern states and later in eight far west states. His aggressive and conscientious work brought about improvements in strategic areas.

A postwar barnstorming tour of important cities by top VD and Social Protection officials plus Mr. Hall—which reached large gatherings of municipal authorities and citizens—apparently clinched wartime gains. Six years later frequent surveys of these formerly wide-open cities find them—with very few exceptions—practically free from commercialized prostitution. Mr. Hall retired from these activities in 1946.

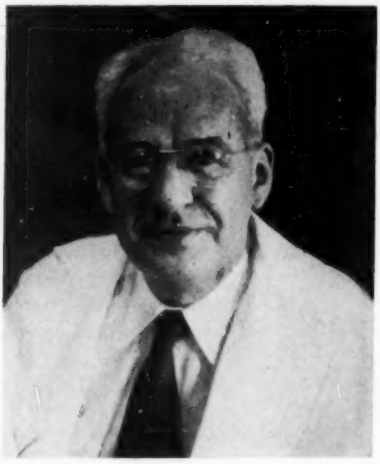
When mobilization began in 1948 and the Defense Department and Public Health Service again needed ASHA's aid, "Johnny-on-the-Spot" came out of retirement to serve as ASHA's director of field services, to recruit and train a new field staff and to re-establish needed services in seven field offices across the country.

Although Mr. Hall has retired from ASHA's full-time permanent staff, he has made himself available for special emergency assignments of the kind which recently took him to Alaska.

Between hither and yon assignments, Mr. Hall edits the New Jersey Health Officers Association's *News Letter*, helps to promote legislation for improved local health administration in New Jersey, and serves as president of the Freehold YMCA board.

He likes to putter around his garden in the summer and to build things in the winter, specializing in flowers, brick fireplaces for backyards, high-class indoor painting and carpentry. He claims to be the slowest—but not the worst—mechanic in the world.

Mr. Hall's contributions to the American Social Hygiene Association and through it to the health and welfare of the nation have been singularly diverse and practical. The Association is proud to include him among its distinguished group of Honorary Life Members.



Chauncey D. Leake

HONORARY LIFE MEMBERSHIP • 1952

As a trail blazer for modern progress in the field of science, Chauncey D. Leake, Litt. B., M.S., Ph. D., educator and medical school administrator, has a breadth and depth of mind that can encompass today's detail and tomorrow's distant goal.

His courtly manner and soft tone of voice belie the aggressiveness with which he cuts through red tape to achieve dynamic results, or the vigorous leadership he gives to his work—whether it is in the meticulous realm of research, in the clarification of social and medical ills, in remedial programs, or in the challenging area of human relations.

Born in Elizabeth, N. J., on September 5, 1896, Dr. Leake early evidenced his interest in science. With degrees from Princeton and the University of Wisconsin, he became an instructor in physiology and pharmacology, spent some time in the Chemical Warfare Service of the U. S. Government in World War I, and in 1928 went to the University of California to organize the department of pharmacology. From there he went in 1942 to the University of Texas as executive vice-president in charge of the medical branch at Galveston.

The record of Dr. Leake's service to humanity is long and varied and includes a wealth of honors:

- as a teacher of pharmacology and the history of science and medicine,
- as a research authority whose contribution to the knowledge of blood production and anesthesia resulted in new inhalation anesthetics and a special award from the International Anesthesia Research Society,
- as a translator of medical classics such as *De Motu Cordis*,
- as an administrator of a pharmacology laboratory which became the training center for pharmacologists and toxicologists,
- as a scientist whose findings protected industrial workers from poisonous new chemicals,
- as a speaker, editor, and writer on medical ethics,
- as an advocate of new drug treatments for amebic dysentery.

In all of these things Chauncey Leake excels.

He has given his inspiration to innumerable offices and to his students, both collectively and individually. He has served as president of the History of Science Society and as chairman of the American Medical Association Section on Pharmacology and Therapeutics. He originated the Family Relations Center of San Francisco and promoted the Planning Commission of that city.

He organized venereal disease control efforts throughout the State of Texas, set up the University of California course on family and human relations, lectured at many universities and colleges, served as honorary consultant to the Army Medical Library and gave invaluable direction to the University of California Medical Library.

Perhaps no more fearless stand against prostitution and related vice has been waged anywhere than in Galveston, where citizens without the support of Dr. Leake's authoritative voice would have feared to take a stand against the entrenched forces of crime. As one facet of the promotion of public health in Texas, Dr. Leake advocates abolishment of segregated districts and suppression of commercialized prostitution, which contributes to the incidence of communicable social diseases.

A singularly erudite and personable individual, he has a diversity of interests that never flag, ranging from enthusiasm for dramatic lighting and public speaking to the serious promotion of the Hoover Commission Report.

In all of his endeavors for the furtherance of science and betterment of human relations, Dr. Leake has had the understanding encouragement of

his wife, formerly Elizabeth Nancy Wilson, whom he married in 1921. They have two sons, Chauncey and William Walker.

The lengthy recording of honors bestowed upon this man of science reveals him to be a man of intellect and vision, of breadth of learning and purposefulness in action.

The Committee on Awards of the American Social Hygiene Association considers it a privilege to acknowledge the contribution of Chauncey D. Leake to the health and welfare of our country by conferring upon him an Honorary Life Membership for his work in social hygiene.

Paul J. Zentay, M.D.

HONORARY LIFE MEMBERSHIP • 1952

Dr. Paul J. Zentay's whole career, whether in private practice or public service, has been strongly affected by his concern with the social aspect of medicine. He has been a teacher, a medical relief official and a public health officer. Since 1934 he has been an officer of the Missouri Social Hygiene Association and actively involved in the development of its program.

Dr. Zentay was born in 1891 in Kovaszna, Hungary, the son of a practicing physician. After completing his general education he studied medicine at the University of Kolozsvar in Hungary.

He graduated from medical school in August, 1914, the first month of World War I. He was called into the Austro-Hungarian army and spent 46 of his 52 months of service at the front.

After the war he became attached to the University of Budapest and served one year in the Department of Pathology and three years in the Department of Pediatrics, where he was director of the laboratories.

His next move was to determine the direction of the rest of his life. In 1921 he accepted appointment as medical director of the American Red Cross in Hungary and organized the child health program there. This work was described—in the final report of the American Red Cross Commission for Europe—as an outstandingly successful project. It also led to his appointment as medical director of the American Red Cross commission on relief for refugees in Greece.

In the latter part of 1923 Dr. Zentay came to the United States, where he worked in the Maryland Department of Health's bureau of child hygiene under Dr. J. H. Mason Knox.

At the invitation of Dr. McKim Marriott, Dr. Zentay came to St. Louis in 1924 to join the faculty of Washington University Medical School. For two years he was a member of the full-time teaching staff as an instructor in pediatrics. In 1926 he changed his status to that of part-time instructor in order to engage in the private practice of pediatrics. Later on, in 1948, he was promoted to assistant professor of clinical pediatrics.

Earlier, in 1933–34, he had interrupted his private practice to take the post of assistant health commissioner for St. Louis. During his term of office an epidemic of encephalitis broke out, known since then as the St. Louis type of that disease. He directed with conspicuous and widely acknowledged success the public health and organizational work made necessary by this crisis.

Diverse activities

The work of a public and social nature carried on concurrently with his private practice has included, among other things, the activities of the St. Louis Pediatric Society's medical milk commission. He was secretary of the commission from 1926 until it ceased operations. In 1933 he was also president of the American Association of Medical Milk Commissions.

Dr. Zentay is the founder and a past president of the Planned Parenthood Association of St. Louis, a member of the board of the Tuberculosis Society, a member of the board of the International Institute, past president of the Public Question Club and past chairman of the Civil Liberties Committee.

In June of 1934 the board of the Missouri Social Hygiene Association elected Dr. Zentay president, the position he held until 1938 when he

became vice-president. He served in this capacity until 1949 when he was again elected president, the post in which he has remained.

During his tenure of these offices a number of important developments have taken place in the field of social hygiene.

Through Dr. Zentay's initiative the St. Louis Health Division's venereal disease control service was modernized and reorganized.

Under his leadership the prenatal blood test bill was enacted by the Missouri legislature. Through this measure the incidence of congenital syphilis has been reduced.

He also was a leader in the fight for enactment of the premarital blood test bill. The educational value of this act has been very great.

Social hygiene teaching in the St. Louis schools was inaugurated by the Board of Education upon the urging of a Missouri Social Hygiene Association committee headed by Dr. Zentay. The first lectures on social hygiene to high school students were delivered by him. After a period of demonstration for two years by the Social Hygiene Association the plan was taken over by the Board of Education and at present is being continued in a greatly expanded form.

The "area project" of the Missouri Social Hygiene Association, which drew nation-wide attention, was initiated upon the advice of Dr. Zentay, who believes that any educational message must be taken to the people in their own neighborhood and that for success their initiative and interest must be enlisted.

During the last 19 years almost any progress made by the Missouri Social Hygiene Association is in some manner and degree connected with the activities of Dr. Zentay.

He is a member of the pediatric staff of the St. Louis Children's Hospital and of the Jewish Hospital, is pediatrician and neurologist of the Shriners' Hospital for Crippled Children, and chief of pediatrics of the Labor Health Institute. Besides his connection with the Department of Pediatrics, he also holds an appointment as instructor in clinical neurology at the Washington University Medical School.

He is married to Elizabeth Grayson and has two sons, John, who is a junior at Harvard, and Peter, who is a senior at John Burroughs School.

To Dr. Paul J. Zentay, in grateful recognition of his valued leadership and many contributions to social hygiene, the American Social Hygiene Association is proud and happy to award an Honorary Life Membership, with the hope that he will long continue to share with us his experienced wisdom.

THE LAST WORD

I personally always had the strong feeling that anybody who is trying to render any kind of public service should not expect and should not even hope for any kind of gratitude or any form of recognition. The work he does carries in itself its rewards; it gives enough satisfaction in the spiritual sense, even though results may not be measured in immediate achievements. Besides, the important point is doing good work for your community even if it is done anonymously, as it is not important where the credit goes as long as the work is done and the community is benefited.

It has been my credo that a man, and certainly a physician, owes much more to the community than just to make a living. Our duty extends far beyond that, and we must try to be leaders and educators in those fields for which we are best suited.

Democracy certainly cannot function and cannot progress without the active and enthusiastic participation of every citizen according to his own lights.

—Paul J. Zentay, M.D.
Honorary Life Member
American Social Hygiene Association

As Secretary of Defense, I regard the United Defense Fund as a distinct asset to our country in these critical times.

It provides a logical, orderly means of unifying and coordinating experienced voluntary national health and welfare organizations for the purpose of serving our present defense effort. The United Defense Fund serves everybody.

Through UDF, members of our armed forces are provided with the morale-strengthening facilities of USO Clubs and Lounges, and USO-Camp Shows. These operations are in action now, in more than two hundred strategic locations at home and overseas.

Two additional member-agencies of UDF are of direct service to military personnel. One is the National Recreation Association, which provides trained personnel for diverse recreation programs conducted on military posts. The other is the American Social Hygiene Association, safeguarding health.

The great humanitarian work of American Relief for Korea, and the important health and welfare tasks undertaken by United Community Defense Services are further reasons why UDF deserves the support of all Americans.